KAISER PERMANENTE®

2005 Colorado Health Plan Description Form
Kaiser Foundation Health Plan of Colorado
Plan 430P – STATE OF COLORADO, Group # 00225

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?[1]	Only for Emergency Care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available only in the following areas: Denver, Broomfield and Boulder Counties and portions of Adams, Arapahoe, Clear Creek, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld Counties.

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
4. ANNUAL DEDUCTIBLE[2]	
a) Individual	No Deductibles
b) Family	No Deductibles
5. OUT-OF-POCKET ANNUAL MAXIMUM[3]	
a) Individual	$3,000/Individual
b) Family	$6,000/Family
c) Is deductible included in the out-of-pocket maximum?	Not applicable
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime Maximum
7A. COVERED PROVIDERS	Colorado Permanente Medical Group, P.C. See Provider Directory for complete list
7B. With respect to network plans, are all the providers listed in 7A. accessible to me through my primary care physician?	Not applicable - this is not a network plan
8. ROUTINE MEDICAL OFFICE VISITS[4]	
a) Primary Care Providers	$30 copay per primary care office visit
b) Specialists	$50 copay per specialist care office visit
9. PREVENTIVE CARE	
a) Children's services	$15 copay per visit
b) Adults' services	$15 copay per visit
10. MATERNITY	
a) Prenatal care	$15 copay per visit
b) Delivery & inpatient well baby care[5]	$1,000 copay per admission
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions**	$15 generic/$40 brand per prescription up to a 30 day supply For drugs on our approved list, please contact your Medical Office Pharmacist
12. INPATIENT HOSPITAL	$1,000 copay per admission

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
13. OUTPATIENT/AMBULATORY SURGERY	$150 copay per visit
14. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI, nuclear medicine, and other high-tech services**	Diagnostic Lab and X-ray - No copay (100% covered) Therapeutic X-ray - $50 copay per visit MRI/CAT/PET - $100 copay per procedure
15. EMERGENCY CARE[7],[8]	$100 copay per visit at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient. Payment of non-Plan emergency claims is limited to usual reasonable and customary charges.
16. AMBULANCE	20% coinsurance up to a maximum of $500 per trip
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$100 copay per visit at a designated Kaiser Permanente emergency room $30 copay per visit at a Kaiser Permanente medical office during office hours $50 copay per after hours visit at designated Kaiser Permanente medical offices
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	Inpatient 50% coinsurance per admission - up to 45 days each calendar year Outpatient - $30 copay per visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.
20. ALCOHOL & SUBSTANCE ABUSE **a) Inpatient** **b) Outpatient**	Inpatient Medical Detoxification - $1,000 copay per admission Detoxification is limited to removing toxic substance from the body Inpatient Residential Rehabilitation - 50% coinsurance up to 45 days each calendar year Outpatient Chemical Dependency - $30 copay per visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	*Inpatient - $1,000 copay per admission for conditions subject to significant improvement within two months *Outpatient - $30 copay per visit for up to two months per condition, or up to 20 visits per condition if 20 or more visits are not received within two months, for conditions subject to significant improvement within two months *Therapy for congenital defects and birth abnormalities is covered for children up to age five for both acute and chronic conditions
22. DURABLE MEDICAL EQUIPMENT	No copay (100% covered) up to $2,000 each calendar year within the Service Area. Prosthetic arms and legs covered at 20% coinsurance with no annual maximum See policy for types and circumstances of coverage
23. OXYGEN	20% coinsurance
24. ORGAN TRANSPLANTS	$1,000 copay per admission - no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea and liver, small bowel/small bowel and liver.
25. HOME HEALTH CARE	No copay (100% covered) for prescribed medically necessary home health services. Not covered outside the Service Area.
26. HOSPICE CARE	No copay (100% covered) for home-based hospice care. Not covered outside the Service Area.

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
27. SKILLED NURSING FACILITY CARE	No copay (100% covered) for up to 100 days for prescribed skilled nursing facility services at approved skilled nursing facilities. Not covered outside the Service Area.
28. DENTAL CARE	Not covered
29. VISION CARE	$30 copay per vision exam Hardware not covered
30. CHIROPRACTIC CARE	$30 copay per visit up to 20 visits each calendar year
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	Travel Clinic for pre-travel health risk assessments, immunizations and prescriptions; Mail-order Pharmacy; Health education classes including Smoking Cessation, Stress Management, Women's Health and Diet and Nutrition; Special Services Hospice program for persons who have not yet chosen hospice care; see attached benefit schedule for cancer screening information

PART C: LIMITATIONS AND EXCLUSIONS

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	Not applicable - Plan does not impose limitation periods for pre-existing conditions
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable - Plan does not exclude coverage for pre-existing conditions
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g. employer). Review the list to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
39. What is the main customer service number?	(303) 338-3800
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Customer Service Center 2500 S. Havana Street Aurora, CO 80014 Telephone (303) 338-3800

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PART D: USING THE PLAN CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42. To assist in filling a grievance, indicate the form number of this policy; whether it is individual, small, or large group; and if it is a short-term policy.	Policy forms LGEOC-DENCOS(01-05) and GA-DENCOS(01-05) Large Group *(Will be available by January 1, 2005)*

Endnotes

[1] "Network" refers to a specified group of physicians, hospital, medical clinics and other health care providers that your plan may require you to use in order to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).
[2] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible may be noted in boxes 8 through 31.
[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.
[4] "Routine medical office visits" include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.
[5] "Well baby care" includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.
[6] "Prescription Drugs" include expendable medical supplies for the treatment of diabetes. Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or nonpreferred.
[7] "Emergency care" means services delivered by an emergency care facility, that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.
[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.
[9] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
[10] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
[11] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

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Selected Benefit Descriptions
Colorado Health Plan Description Form Addendum
Kaiser Foundation Health Plan of Colorado

Benefit	Benefit Level
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	*Kaiser Permanente Coverage for Cancer Screening*

Breast Cancer:

Screening	Coverage	Kaiser Permanente Recommendation
Clinical breast exam	Not limited	As jointly determined by physician and patient.
Mammogram	Available for all women upon request beginning at age 40	At least every 2 years beginning at age 50
Genetic testing for inherited susceptibility for breast cancer	Available upon referral of a Kaiser Permanente provider for those women who meet the following criteria: • Patients with a 10% or greater risk of inherited gene defect	

Colon and Rectal Cancer:

Screening	Coverage	Kaiser Permanente Recommendation
Fecal occult blood test (FOBT)	Not limited	Annually beginning at age 50 through age 75
Flexible sigmoidoscopy	Not limited	Every 5 – 10 years beginning at age 50 through age 75
Barium enema	Not limited	Every 5 years beginning at age 50 through age 75
Colonoscopy	Every 10 years, more frequently for high risk patients – as determined by a Kaiser Permanente physician	Every 10 years, more frequently for high risk patients – as determined by a Kaiser Permanente physician

Cervical Cancer:

Screening	Coverage	Kaiser Permanente Recommendation
Pap test	Not limited	Annually for women under age 26. After that, recommended every 2 years after 3 normal annual screenings, for women up to age 65.

Prostate Cancer:

Screening	Coverage	Kaiser Permanente Recommendation
Digital rectal exam	Not limited	Patients should discuss the benefits and risks of this test with their Kaiser Permanente physician.
Serum prostatic specific antigen (PSA)	Not limited	Patients should discuss the benefits and risks of this test with their Kaiser Permanente physician. Not recommended for those over 70.